Family Nursing & Home Care

Standard Operating Procedures

‘Trial without Catheter’ (TWOC) in the Community

February 2023

Document Profile

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Author(s)	Fiona Le Ber, Clinical Nurse Specialist for Bladder and Bowel
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Version Control / Changes Made

Date	Version	Summary of changes made
December 2022	1	Changed from Policy to SOP Added SOP for Suprapubic catheter TWOC How to teach Intermittent Self Catheterisation (ISC) added Patient ISC Checklist added Algorithm and references updated Bladder scanning SOP updated to reflect Bard Scanners Home to hospital liaison form removed and Catheter passport added

Contents

Introduction

'Trial Without Catheter' (TWOC) is the term used when a catheter, which has been inserted via the urethra into the bladder or via the supra-pubic site for drainage purposes, is removed for a trial period to determine whether the patient is able to pass urine safely and spontaneously without the need for further catheterisation. A TWOC is used to test a patient's voiding function post-operatively, after an episode of acute urinary retention or, in men, to determine the effectiveness of alpha-blockers (RCN 2019). Urinary catheters should be removed or clamped as soon as the catheter is no longer indicated. (Place 2022)

The aim of this document is to enable TWOC to be undertaken safely in the community. TWOC should only be undertaken by qualified nursing staff competent in this area of practice.
If an HCP considers a patient no longer needs a catheter, it is important to perform a TWOC. If the TWOC is unsuccessful, a new catheter merely needs inserting or the patient can perform ISC – removing the catheter will not harm the patient. (Urinary catheterisation Best Practice Statement 2022).

The benefits of TWOC, being undertaken in the community setting include:

- improved patient outcomes as the intervention will be completed in their home environment
- reduced risk of acquiring infection as patients remain in their own home environment
- freeing of acute hospital beds thus preventing cancellation of operations
- addressing the difficulty of bed space which potentially results in catheters being left in situ longer than necessary, again increasing the risk of urinary tract infection
- preventing unnecessary admission of patients who are elderly with mobility problems who may require hospital transport to attend to hospital (RCN 2019)

A flowchart for Trial Without Catheter is available in Appendix 1.

SOP 1 Assessing a Patient for Trial Without Catheter (TWOC)

Purpose

To assess patients prior to undertaking TWOC in the community, in order to promote success of the procedure and patient safety.

Scope

All patients referred or being considered for TWOC in the community.

Core Requirements

On receipt of referral or when considering TWOC, review the patient's records to assess their suitability for TWOC against the following indications and contraindications:

Indications for TWOC in the community

The following conditions/situations are suitable for TWOC in the community:

- acute urinary retention and commenced on alpha blockers
- post trans-urethral resection of prostate(TURP) / Plasma
- post urolift surgery
- Radical prostatectomy
- Catheterisation for co-morbidities
- Removal of supra-pubic catheter

Contraindications for TWOC in the Community

The following conditions/situations are contraindicated for TWOC in the community:

- Bladder neck incision within the last eight weeks
- Optical urethrotomy within the last eight weeks
- Open or endoscopic prostatectomy within the last eight weeks
- Urethral stricture
- Undiagnosed haematuria
- Clot retention
- Systemically unwell
- Patients who are constipated - with no bowel movement for 3 days or more
- Confirmed urinary tract infection or recurrent urinary tract infections
- Raised pressure chronic retention (unless TWOC instructed by the urologist)

- Hydronephrosis
- Known pathology of the lower urinary tract, such as cancer
- Patients who are not alert, orientated or have poor cognitive function and are unable to concord with treatment regime.
- Patients who withhold consent. If the patient lacks capacity then TWOC can be carried out in 'Best Interests' using the Mental Capacity Act. This must be fully documented (Nazarko 2020)
- Patients who have documented previous difficulty with urethral catheterisation.
- Patients, families or carers who are unable to alert the community nurse of any difficulties when undergoing a TWOC

Contraindications for SPC TWOC

- permanent or a long term SPC that has been inserted for:
    - repeated failed or difficult urethral catheterisation,
    - established urethral pathology i.e. dense stricture /false passage/abnormally enlarged prostate/ awaiting formal surgery
    - If in doubt, don't TWOC.

If assessed as suitable for TWOC, contact patient, explain procedure and plan date for TWOC including a pre TWOC visit.

Discuss that a chaperone can be provided if the patient wants one – document response.

SOP 2 Visit 1 - Pre-Procedure Counselling

Purpose

To ensure the patient is fully prepared for the forthcoming TWOC.

Scope

Registered Nurses who are competent in undertaking TWOC.

Core Requirements

Visit 1 should happen the day before TWOC is undertaken.

Explain procedure and give patient TWOC information leaflet (Appendix 2).

Discuss potential risks.

For male patients with benign prostatic enlargement an Alpha-blocker* e.g. Tamsulosin 400mcg or Alfuzosin XL 10mg should be commenced if appropriate 48 hours before the TWOC. (Place 2022). *Alpha-blockers relax the internal sphincter, improve urine flow rate and the ability to empty the bladder.

Explain to the patient that should the TWOC be unsuccessful then they will need to be re-catheterised or taught Intermittent Self Catheterisation (ISC).

Check when the patient last opened their bowels. Advise the patient that if constipated the TWOC will be deferred. The patient would ideally have opened his/her bowels within the 24 hours before the TWOC (Colemeadow 2018).

Explain the benefits of a catheter valve and replace leg bag with valve. Catheter valves have the potential to improve TWOC outcomes (Holroyd 2021) unless contraindicated e.g. impaired renal function, post-bladder or prostate surgery poor manual dexterity (McNaughton 2022), chronic retention or "floppy bladders".

If the patient has a catheter valve ask the patient to empty the bladder using the catheter valve at 6.30am on day of TWOC and not to empty it after that.

Check medication to ensure that those on diuretics are aware of the need to take medication on the morning of the procedure.

Explain how to monitor fluid intake and urine output and complete charts

Encourage the patient to drink normally (1.5 to 2 litres during the day) the day prior to TWOC, as over consumption of fluids may compromise bladder function (RCN 2019).

SOP 3 Visit 2 - Day 1 Undertaking the TWOC Procedure

Purpose

To enable TWOC to be carried out safely and successfully

Scope

Registered Nurses who are competent in undertaking TWOC

Core Requirements

TWOC should be undertaken on a weekday (not a Friday if possible) between 8.30-9.00hrs.

Prior to the visit, assemble all necessary equipment

Equipment required:

- Disposable Gloves and Apron
- Syringe for deflating balloon
- Specimen container if CSU required
- Bladder Scanner
- "TWOC Box" –with contents for replacing catheter and Intermittent catheter
- supplies
- Appropriate documentation

Check again that there are no contraindications for TWOC in the Community. If the patient appears unwell, the TWOC should be deferred.

To ensure that the patient understands the procedure and gives his valid consent, explain to patient that should the TWOC be unsuccessful then they will need to be re-catheterised or taught Intermittent Self Catheterisation (ISC)

Confirm when the patient last opened their bowels (also see SOP 2).

If the patient has a catheter valve patient, confirm that they have emptied the bladder using the catheter valve at 6.30am and have not emptied it after that.

Complete the 'Trial without Catheter (TWOC) checklist (Appendix 3).

Obtain verbal consent and offer a chaperone, document response.

Attach pre-written care plan to EMIS record.

To prevent cross infection, ensure patient has washed perineum prior to catheter removal (assist with this if necessary).

Remove catheter between 8.30-9am (having confirmed that patient last emptied bladder at 6.30 am), using clean technique.

If the patient has forgotten to empty their bladder at the required time, the timings for catheter removal will need to be adjusted, to allow the bladder to fill sufficiently.

Advise patient re fluid intake - ask the patient to drink 200ml of fluid each hour or 1L by 1pm (4 hours later) and to record fluid intake and output on a fluid balance chart (Appendix 4). This level of fluid intake will enable the bladder to sufficiently fill before voiding so that trial without catheter can be monitored within a reasonable period (Nazarko 2020).

Advise the patient to take meals as normal.

Explain to the patient that the first void may sting and they may see a little blood, due to trauma of removing the catheter.

Inform patient of possible symptoms, such as urinary urgency, frequency and discomfort (caused by inflammation of the urethra following prolonged catheterisation). Knowing what to expect will enable the patient to plan daily activities.

Give patient contact numbers in case of any problems and explain follow up procedure for that day.

Make contact with patient after 4 hours (maximum) to monitor progress and check fluid intake (where appropriate this may be by telephone). If patient is unable to void and is uncomfortable arrange to perform bladder scan (see SOP 6).

Remind patient of timing for next visit (see SOP 4).

SOP 4 Visit 3 - Day 1 Monitoring Success of TWOC

Purpose

To monitor success of TWOC 8 hours post removal of the catheter.

Scope

Registered Nurses who are competent in undertaking TWOC.

Core Requirements

This visit should be undertaken 8 hours post removal of the catheter

Review fluid balance chart to check passing urine of at least 100mls at each void.

If not, assess the need to perform a bladder scan (SOP 6) or insert catheter to check residual volume.

TWOC is successful if:

- the patient is passing urine
- the residual volume is 400mls or less
- the patient is comfortable

If successful, leave catheter out and follow up on Day 3 (SOP 5).

TWOC is unsuccessful if:

- the residual volume is more than 400ml
- the patient is uncomfortable

If TWOC unsuccessful, initiate Intermittent Self-Catheterisation (ISC) (Appendix 8), discuss ISC Checklist with patient & continue to prompt urination. Continue ISC until Day 3.

Suitability for ISC includes patient consistency, willingness, satisfactory cognitive function and adequate manual dexterity. Conversely, ISC is generally unsuitable for patients with overactive bladders (BAUS 2021)

If unsuitable for ISC, re-catheterise with a Foley catheter size 12ch – 14ch using aseptic technique, adhering to the FNHC Management of Urinary Catheterisation (Adults) Guidelines and SOPs.

If unable to re-catheterise: liaise with the Surgical Registrar on Call at Jersey General Hospital to arrange reinsertion, send patient with their Catheter Passport (Appendix 6)

Ensure that the patient knows who to contact if any problems experienced between 17.00 – 22.30 (Twilight District Nurse or Out of Hours Service (tel. 442000))

SOP 5 Visit 4 - Day 3 Routine Follow-Up

Purpose

To monitor the success of TWOC.

Scope

Registered Nurses who are competent in undertaking TWOC.

Core Requirements

Visit patient on Day 3 to assess progress.

If patient comfortable and passing urine spontaneously, email completed outcome form to urology-continencenurses@gov.je

TWOC is unsuccessful if patient unable to spontaneously pass urine or residual volume is more than 400ml & patient is uncomfortable.

If performing intermittent self-catheterisation (ISC):

- check competence of technique
- order catheter/ISC supplies
- if 1st TWOC arrange to repeat TWOC in two weeks (Day 14 SOP 6))

SOP 6 Visit 5 - Day 14 Undertaking the 2nd TWOC Procedure (if 1st TWOC unsuccessful)

Purpose

To enable TWOC to be carried out safely and successfully

Scope

Registered Nurses who are competent in undertaking TWOC

Core Requirements

TWOC should be undertaken on a weekday (not a Friday if possible) between 8.30-9.00hrs.

Prior to the visit, assemble all necessary equipment

Equipment required:

- Disposable Gloves and Apron
- Syringe for deflating balloon
- Specimen container if CSU required
- Bladder Scanner
- "TWOC Box" –with contents for replacing catheter and intermittent catheter supplies
- Appropriate documentation

Check again that there are no contraindications for TWOC in the Community. If the patient appears unwell, the TWOC should be deferred.

To ensure that the patient understands the procedure and gives his valid consent, explain to patient that should the TWOC be unsuccessful then they will need to be re-catheterised or taught Intermittent Self Catheterisation (ISC)

Confirm when the patient last opened their bowels (also see SOP 2).

If the patient has a catheter valve patient, confirm that they have emptied the bladder using the catheter valve at 6.30am and have not emptied it after that.

Complete the 'Trial without Catheter (TWOC) checklist (Appendix 3).

Obtain verbal consent and offer a chaperone, document response.

Attach pre-written care plan to EMIS record.

To prevent cross infection, ensure patient has washed perineum prior to catheter removal (assist with this if necessary).

Remove catheter between 8.30-9am (having confirmed that patient last emptied bladder at 6.30 am), using clean technique.

If the patient has forgotten to empty their bladder at the required time, the timings for catheter removal will need to be adjusted, to allow the bladder to fill sufficiently.

Advise patient re fluid intake - ask the patient to drink 200ml of fluid each hour or 1L by 1pm (4 hours later) and to record fluid intake and output on a fluid balance chart (Appendix 4). This level of fluid intake will enable the bladder to sufficiently fill before voiding so that trial without catheter can be monitored within a reasonable period (Nazarko 2020).

Advise the patient to take meals as normal.

Explain to the patient that the first void may sting and they may see a little blood, due to trauma of removing the catheter.
Inform patient of possible symptoms, such as urinary urgency, frequency and discomfort (caused by inflammation of the urethra following prolonged catheterisation). Knowing what to expect will enable the patient to plan daily activities.
Give patient contact numbers in case of any problems and explain follow up procedure for that day.
Make contact with patient after 4 hours (maximum) to monitor progress and check fluid intake (where appropriate this may be by telephone). If patient is unable to void and is uncomfortable arrange to perform bladder scan (see SOP 7).
Remind patient of timing for next visit (see SOP 4).

SOP 7 Undertaking the TWOC Procedure FOR A Supra-pubic catheter (SPC)

Purpose

To enable TWOC to be carried out safely and successfully

Scope

Registered Nurses who are competent in undertaking TWOC

Core Requirements

TWOC should be undertaken on a weekday (not a Friday if possible) between 8.30-9.00hrs.

Prior to the visit, assemble all necessary equipment

Equipment required:

- Disposable Gloves and Apron
- Appropriate documentation

Check again that there are no contraindications for TWOC in the Community. If the patient appears unwell, the TWOC should be deferred.

To ensure that the patient understands the procedure and gives his valid consent, explain to patient that should the TWOC be unsuccessful then the Supra pubic catheter will remain insitu

Confirm when the patient last opened their bowels (also see SOP 2).

Confirm that they have emptied the bladder using the catheter valve at 6.30am and have not emptied it after that.

Complete the 'Trial without Catheter (TWOC) checklist (Appendix 3).

Obtain verbal consent and document response.

Attach pre-written care plan to EMIS record.

Day 1 – Clamp at 8.30, ask the patient to drink at least 250ml of fluid each hour and to record fluid intake as wells as record voids and residuals on a fluid balance chart (Appendix 4). Unclamp the SPC immediately after each void, record void and residual then re-clamp.

Day 2 – drink at least 250ml of fluid each hour. Record voids only during the day, do a single residual at bedtime (if the patient is uncomfortable during the day, they can do a residual each time)

Day 3-14- drink normally, record voids only. If voids 200ml or more and residuals 50mls or less, then the SPC can be removed on day 14.

Day 14 – Remove SPC early, then record voids during the day.

Advise the patient to take meals as normal.

Explain to the patient that the first void may sting

Inform patient of possible symptoms, such as urinary urgency, frequency and discomfort .Knowing what to expect will enable the patient to plan daily activities.

Give patient contact numbers in case of any problems and explain follow up procedure for that day.

Make contact with patient after 4 hours (maximum) to monitor progress and check fluid intake (where appropriate this may be by telephone). If patient is unable to void and is uncomfortable unclamp the catheter.

Remind patient of timing for next visit (see SOP 4).

Monitoring Success of TWOC Follow up **Day 14**

If voids consistently 200ml or more and residuals 50mls or less, then the SPC can be removed.

Remove SPC early, then record voids during the day.

Apply small dry dressing over site and advise the patient that this may leak over next few days and to keep replacing the dressing as required.

SOP 8 Procedure for Use of the Bladder Scanner

Purpose

To provide a safe, effective and standardised procedure for undertaking a portable bladder scan

Scope

All adult patients where a bladder scan is required as part of the TWOC procedure, where TWOC is requested or required.

Core Requirements

Refer to Bladder Scanner user Instructions (Appendix 9)

Assemble all necessary equipment:

- Bladder scanner
- Ultrasound gel
- Wipes

Explain and discuss the procedure to the patient

Ensure privacy

Wash hands with liquid soap and water, dry thoroughly with paper towel.

NB. If in patient's own home, use liquid soap and water, dry with kitchen roll. If these facilities are not available, use alcohol hand gel. (Refer to Infection Prevention & Control Policy/Procedure Hand Hygiene and the Use of Personal Protective Equipment)

Assemble the bladder scanner according to the manufacturer's instructions.

Switch On – Press the BLACK button at the back.

To achieve appropriate position and access to patient, assist the patient into a supine position with head raised.

Place an ample quantity of ultrasound gel on the probe head.

Palpate the patient's pubic bone and place the probe midline on the patient's abdomen, approximately one inch (3 fingers) above the pubic bone.

Standing at the patient's side, place the probe on the gel and aim towards the expected location of the bladder. For most people this means tilting the probe slightly towards the patient's coccyx. This enables the scan to clear the pubic bone to aid view of the bladder. Positioning of the probe is vital to gain the best picture.

First find the pubic symphysis and then start to scan, two fingers widths up from there, angle down towards the patients feet

Perform Transverse Scan – probe ridges to patient's head right/BLUE button to patient's head. Press SCAN or BLUE probe button to record accurate measurement of bladder image and volume.

Press FREEZE or BLUE probe button – this is your interim or quick scan reading.

Perform a SAGITAL SCAN – probe ridges to patient's head/BLACK dot, Press SAGITAL SCAN on screen

Press FREEZE or BLUE probe button to freeze. THIS IS YOUR FINAL COMBINED READING

PRESS RED BUTTON ON SCREEN TO FINISH

At the end of the procedure the scanner head should be wiped free of gel and cleaned with a detergent wipe.

Remove the remaining gel from the patient's abdomen using wipes and allow the patient to redress.

Ensure all waste is disposed of in line with FNHC policy.

Wash hands (refer to Infection Prevention & Control Policy/Procedure Hand Hygiene and the Use of Personal Protective Equipment)

Explain the results to the patient.

SOP 9 Procedure for Intermittent Catheterisation

Purpose

To provide a safe, effective and standardised procedure for undertaking Intermittent Catheterisation

Scope

All adult patients where Intermittent Catheterisation is indicated (Appendix 5).

Core Requirements

Assemble all necessary equipment required:

- Personal protective equipment
- Appropriately sized intermittent catheter

Optional equipment

- Suitable container (clean jug or receiver) if required
- Mirror if required

Explain and discuss the procedure with the patient

Gain consent and offer chaperone

Ensure curtains / blinds and doors are closed

Prepare work surface, clean box lid with Clinell wipe

Assist the patient to get into the supine position with the legs extended on the bed.

Remove patient's underwear. Assist patient to get into the supine position with knees bent, hips flexed and feet resting about 60 cm apart.

Place a towel over the patient's thighs and genital area.

Ensure that a good light source is available.

Wash hands using soap and water or bactericidal alcohol hand rub.

Put on a disposable apron.

Open catheter packaging or container. If using an uncoated catheter, a water soluble lubricating gel may be applied to the surface of the catheter.

Hold the catheter with the dominant hand, being careful not to touch the part of the catheter entering the body, and gently insert it into the opening of the urethra. Advance the catheter into the bladder.

Drain the urine into the toilet or suitable container. When the urine stops flowing, slowly remove the catheter, halting if more urine starts to flow.

Assist the patient to replace underwear and pyjamas and replace bed cover. Ensure that the area is dry. If the area is left wet or moist, secondary infection and skin irritation may occur.

Measure the amount of urine. This will provide an awareness of bladder capacity for patients who have presented with urinary retention. It also enables renal function and fluid balance to be monitored.

Dispose of equipment including apron and gloves in a plastic waste bag and seal the bag. Dispose of waste bag in a larger bin.

Wash hands thoroughly with soap and water.

Complete all documentation to provide a point of reference or comparison in the event of later queries

SOP 10 Procedure for Teaching Intermittent Self Catheterisation (ISC)

Purpose

To provide a safe, effective and standardised procedure for undertaking intermittent catheterisation.

Scope

All adult patients where intermittent catheterisation is indicated (appendix 5)

Core Requirements

Although ISC is a fairly simple procedure, it is important that patients are shown how to perform it safely and are supervised and supported until confident and competent to do so independently. (Leaver 2022)

The patient will need to have manual dexterity to handle the catheter and cognitive ability to perform the procedure cleanly and the willingness to take ISC on for as long as required. (Leaver 2022)

Community nurses are ideally placed to teach patients to self-catheterise (Balhi 2021)

It is important that ISC be performed often enough to prevent bladder distension. Inform patient how often it needs to be done and why. The frequency will depend on the individual's bladder assessment and may be up to six times daily for bladder emptying. Encourage daily urinary output of 1.5 to 2 litres and so as not to exceed the 400 ml residual volume (Balhi 2021).

Procedure

Assemble Patient Information leaflet and all necessary equipment, as per SOP 7.

Inform the patient what ISC involves and the importance of carrying out a clean procedure.

A clean technique is used in the patient's home.

Patients should identify a position that is comfortable for them to undertake ISC, for example:

- Sitting on the toilet
- Standing over the toilet
- Sitting on a chair or side of the bath
- One leg slightly elevated on a stool
- Sitting in a wheelchair
- Lying on one side in bed

Patients with a large abdomen may find it easier to stand in front of a mirror so they can see what they are doing.

Patients must be taught the importance of hand hygiene, including cleaning their nails. They should wash their hands before starting the procedure to prevent infection.

Patients should prepare the catheter according to the manufacturer's instructions.

They should try to pass urine before performing catheterisation if possible to empty the bladder as normal. The true residual volume is based on the volume drained during ISC and these volumes are used to calculate the number of times the procedure needs to be performed in 24 hours.

Wash the genital area. Female patients should wash from the urethra towards the anus to prevent infection. They should be advised to part the labia with the index and middle fingers of their non-dominant hand, and identify the urethra. Some women like to use a mirror others prefer to identify the urethra by touch.

Male patients should retract the foreskin to clean the glans and be advised to hold the penis with their non-dominant hand pointing in an upward direction towards the stomach. This helps to extend the urethra and makes it easier to insert the catheter.

The patient should gently insert the catheter into the bladder using the dominant hand while pointing the funnel end into the toilet or jug.

While inserting the catheter the patient should avoid touching the part of the catheter that will enter the urethra. To ensure catheter is in the bladder, the patient should continue to insert the catheter until urine starts to flow.

When urine stops flowing, the patient should slowly remove the catheter. If urine starts to flow again, the patient should wait then gently begin to withdraw the catheter to catch any last drops.

To avoid any dribbles or spillage, they should place a finger over the funnel to trap the residual urine in the catheter before finally removing it from the urethra and emptying it into the toilet or receptacle.

The patient should dispose of the catheter according to the manufacturer's instructions. Catheters should not be flushed down the toilet as they may cause a blockage.

The patient should wash and dry their hands.

Patients should be provided with information leaflets and monitoring charts. They should also be advised on:

- hygiene needs
- fluid intake
- signs of infection
- the make and type of catheter they use, and how to order further supplies

References

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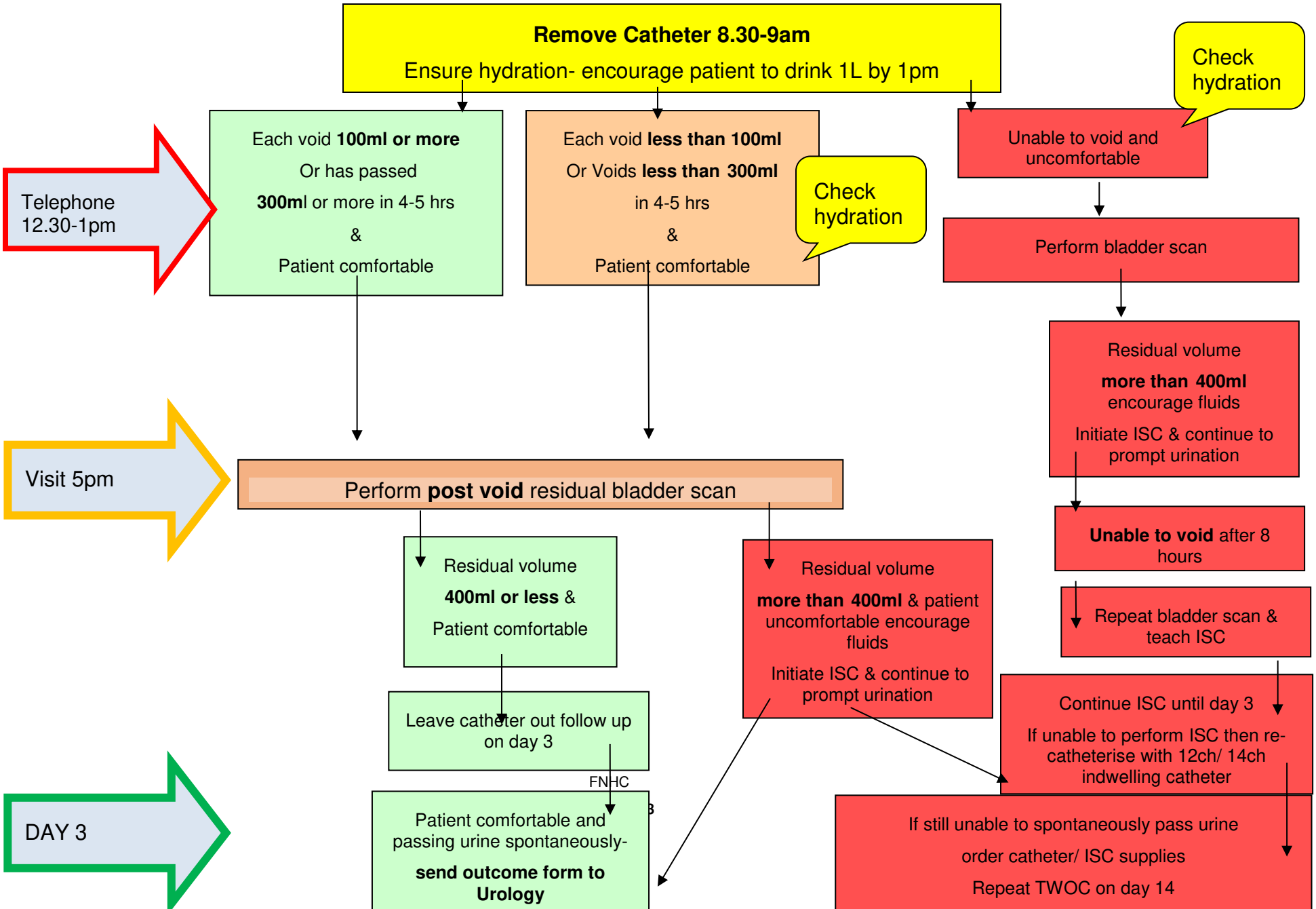
Appendix 1 TWOC Flowchart



Appendix 2 Patient Information Leaflet – Trial Without Catheter (TWOC)

TWOC leaflet 2022.pub

Appendix 3 Trial Without Catheter Checklist

Trial without Catheter (TWOC) Checklist

Name:.....

D.O.B:.....

Removal Requested By: .....

Designation:

Indications for TWOC in the Community ……..

Contra-indication/s for TWOC in the community present: yes □ no □
if '**yes' do not proceed**

Pre TWOC counselling undertaken: yes □ no □
if '**no' do not proceed**

Patient consent obtained and care plan signed: yes □ no □
if '**no' do not proceed**

Signs of urinary tract infection present: yes □ no □
if '**yes' do not proceed**

Normal (for the patient) bowel movement in last 24 hours yes □ no □
if '**no' do not proceed**

Date Catheter Removed: …….. **Time Catheter Removed:** ……

Signature of Nurse: ……**Designation:** ...……

DISTRICT NURSE TO COMPLETE THIS SECTION AT 3RD VISIT POST TWOC (tick as appropriate)

Bladder control during trial: (patient states) Good ☐ Fair ☐ Poor ☐

Bladder emptying: Completely ☐ Partially ☐ Not at all ☐

Perform Bladder scan to determine post residual volume.

Outcome: complete outcome form and email to urology-continencenurses@gov.je

Comments:

Appendix 4 TWOC Diary - Fluid Balance Chart

Trial without Catheter (TWOC) Diary

Daytime Contact Number:

.....

Out of Hours Contact 442000 Ask for District Nurses

PATIENT INSTRUCTIONS

1. **PLEASE empty bladder at 6.30 am and clamp catheter**
2. Please drink at regular intervals throughout the day to comfortably fill your bladder. **Aim to drink 1L by 1pm**
3. Please measure and record all fluids drunk and all urine passed
4. **If at any time during you cannot pass urine and it becomes uncomfortable, please contact the Nurse**

PLEASE COMPLETE THIS SECTION

TIME	INTAKE	OUTPUT	TIME	INTAKE	OUTPUT
0830			1230		
0900			1300		
0930			1330		
1000			1400		
1030			1430		
1100			1500		
1130			1530		
1200			1600		
Total	**input**		**output**		

Appendix 5 Intermittent Self Catheterisation

Should the trial without catheter be unsuccessful, Intermittent bladder drainage is considered to be best practice (NICE, 2015, RCN 2019).

Intermittent Self Catheterisation (ISC) can be used to manage voiding for individuals with various problems, including those who, are usually managed with indwelling catheters.

The main advantages of ISC are:

- Preventing or overcoming infection by regular emptying of the bladder
- No real increased infection rate using a clean rather than a sterile procedure
- Promoting a 'normal' pattern of filling and emptying stages of micturition
- Protecting the upper urinary tract
- Improving symptoms
- Promoting independence
- Improving quality of life

Indications for the use of ISC include:

Incomplete emptying:

- neurogenic or hypotonic bladders
- failure of the bladder outlet to open to allow the passage of urine through it eg. prostate enlargement in men or after surgery for stress urinary incontinence
- Detrusor hypo contractility/failure:
- spinal injuries and neurological disorders such as multiple sclerosis
- urethral strictures (Yates 2017)

Contraindications and precautions in the use of ISC:

- false passage down the urethra
- those who have had trauma to the penis
- tumour or other injury

It should be used with caution following prostatic or urethral and bladder surgery, in patients with urethral stents or artificial prosthesis, or those with a tendency to bleed (RCN 2019).

Gaining consent

When gaining consent from a patient to perform intermittent self-catheterisation, the following must be covered:

- Rationale for intermittent self-catheterisation
- Information on lifestyle and disability
- The procedure may be lifelong and performed several times each day
- The positive benefits of intermittent self-catheterisation, including increased independence
- The negative risks and common complications
- The need for continual follow up and regular review

Criteria for successful intermittent self-catheterisation, the patients must:

- Be able to store urine in their bladder
- Be able to understand the technique for ISC;
- Have reasonable dexterity and enough strength to be able to correctly hold and insert the catheter
- Be able to position themselves into a suitable position to undertake the procedure
- Be motivated to commit to the procedure, which could be a lifelong commitment. (Yates 2017)

Appendix 6 Intermittent Catheterisation Patient Checklist

1. WHY USE A CATHETER?

	Tick
Has a suitable explanation been provided to explain why your bladder is not emptying properly?	☐
Has this explanation been understood?	☐

2. PREPARING TO CATHETERISE

Have you been advised to check the expiry date on the packaging?	☐
Have you been advised to make sure the packaging is not broken before use?	☐
Have you been shown how to prepare for the catheter insertion?	☐
Have you discussed and agreed, with your healthcare provider, a suitable place to perform catheterisation at home/work/school?	☐
Is a pass key required to access the facility?	☐
Have carers been identified to support the child/student in a school/college setting?	☐
Has a place for the storage of medical supplies been identified in work/school/college?	☐
Has the importance of hand washing prior to catheterisation been explained?	☐

3. INSERTING AND REMOVING THE CATHETER

Have you been shown and are you able to perform different positions for ISC?	☐
Have you received and understood instructions on how to handle a sterile catheter?	☐
Have you been advised that you will need a suitable container to drain urine into?	☐
Have you been given guidance on how to locate your urethra?	☐
Have you been instructed on how to locate your urethra?	☐
Have you been instructed on how far to insert the catheter?	☐
Have you been advised to remove the catheter slowly when the urine stops draining?	☐
Do you understand why you must never re-use a catheter?	☐
Do you understand how to measure and note the amount of urine drained?	☐
Have you received instruction on how to safely dispose of a used catheter?	☐

4. FREQUENCY OF CATHETERISATION

How many times a day have you been asked to catheterise?	☐

5. OBTAINING YOUR MEDICAL SUPPLIES

Have you received advice on how to obtain your catheter supplies?	☐
Do you understand how to avoid running out of catheters?	☐

6. STORAGE OF CATHETERS

Do you agree to store your catheters according to the manufacturer's instructions?	☐

7. COMMON COMPLICATIONS

Have you received guidance on how to recognise a urinary tract infection? ☐

Have you received instruction on what to do if you see blood in your urine? ☐

Do you understand what to do if you see blood in your urine? ☐

Do you understand what to do if you cannot take your catheter out? ☐

Do you understand what to do if no urine drains from your catheter? ☐

8. FOLLOW UP AND FURTHER APPOINTMENTS

Do you know how to get in touch with the District Nurse or urology team? ☐

9. ADDITIONAL INFORMATION

Have you received advice on the importance of drinking fluids? ☐

Do you understand how your bowel can also affect your bladder? ☐

10. RECOMMENDED PRODUCT

Make of catheter (name of manufacturer and brand name)_____

Charrier size (CH06-CH18)_____

Type (Straight tip/Tiemann/Coude tip/Integrated urine collection bag)_____

Length (Male 15cm/20cm) 40cm/Female _____

I confirm that a clear and thorough explanation of the above procedures has been provided.

Patient

Print name Signature Date

_____

Healthcare Professional

Print name Signature Date

_____ _____ ___

Adapted from University of Morcambe Bay Hospital with permission by FLB 2022

Appendix 7 Catheter Passport

catheter passport May 2020V4.pub

Appendix 8 TWOC Outcome Form

Government of JERSEY

Health & Community Services

Trial without Catheter (TWOC)

Patient Name ……..

URN ……..

DOB ……

Trial without Catheter (TWOC) Outcome

Please complete day 3 post TWOC and /or Day 17 post TWOC

Date 1st TWOC was carried out on this Client: ……

Date 2nd TWOC was carried out on this Client ……..

The TWOC was (Please tick);

Successful ☐ Unsuccessful ☐

If successful advise client to continue on Tamsulosin or Alfuzosin that should have been started by the hospital

Outcome - ……

……

……

If the client is suffering with any incontinence please write a temporary voucher to obtain 3 month supply of pads via the subsidised scheme. Please tick the box if a voucher has been written ☐

Name of staff completing this form ……..

Signature……..…….

This form **must** be emailed to Urology & Continence Nurses urology-continencenurses@gov.je

Appendix 9 Bardscan Instruction Presentation